California's Health

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STATE LAW AND ADMINISTRATION OF DISTRICT HOSPITALS*

GORDON R. CUMMING, Chief
Bureau of Hospitals, California State Department of Public Health

In discussing state law relating to administration of district hospitals, it is unnecessary for me to make clear to this group that I am not an attorney and will not attempt to cover the district law generally. Instead, I shall try to relate my comments to areas in which the State Department of Public Health has knowledge based on direct responsibilities and experience.

Before getting into a discussion of the Hospital District Act, a few observations regarding other laws may be of interest. Operation of all hospitals, whether they are nonprofit, proprietary, city, county or district, are controlled in various ways by state laws. One of the most significant of these laws is the Medical Practice Act, which defines the role of the physician, as distinguished from the role of the hospital, in patient care. There also are other laws which relate to the health professions, for example, those relating to registration of nurses, vocational nurses, and laboratory personnel. All hospitals in California, except those operated by the federal and state governments, are required to comply with the Hospital Licensing Act and regulations established under it. In addition to these general laws which are applicable to all hospitals, there are special laws governing various types of hospitals. Nonprofit hospitals have special laws relating to formation of nonprofit organizations and on tax exemption. County hospitals have their activities established in the Welfare and Institutions Code.

District hospitals are governed by Sections 32000-32499 of the Health and Safety Code. The State Department of Public Health has these sections reprinted periodically in booklet form. The Hospital District Act contained in these sections began as a relatively simple declaration of the purpose and organization of district hospitals. During the past 15 years there have been numerous amendments. Most of the amendments which have occurred can be classified into three groupings:

1. *Amendments Establishing More Specific Legal Provisions for Forming and Operating Districts.* These include technical provisions, language to create specificity, and procedural matters.
2. *Amendments Relating to Medical staffing and Relationship with Medical Practice.* Section 32128 establishes qualification and organization of the medical staff, with particular regard to doctors of medicine and doctors of osteopathy. The section also requires that minimum staffing standards in district hospitals meet those in private and voluntary hospitals. Section 32129 provides that districts cannot furnish professional service and cannot make a profit on the practice of medicine under contracts which may be executed with physicians.
3. *Amendments or Relationship with Other Hospitals.* Section 32002 requires, in the formation of a hospital district, that a certification be obtained from the State Department of Public Health on need for beds in the hospital service area to be served and fulfillment of this estimated need by existing facilities. Sections 32127 and 32221 limit the right of the board to build additional beds, except as authorized by popular vote. Section 32125 expresses the philosophy that district hospitals shall be self-sufficient insofar as possible and shall establish rates to cover cost and shall not provide care for medical indigents at less than cost. Section 32201 requires the district board, each year, to certify to the board of supervisors that rates and charges are comparable to those established by nonprofit hospitals in the same service area.

In view of the very rapid expansion of hospitals throughout California and the dynamic contribution district hospitals have made to this expansion, it is not surprising that relationship with medical practice and with other hospitals has received active legislative consideration. In this regard, it may be well to mention that 12 years or so ago when hospital districts were being formed very rapidly, some people assumed the State Department of Public Health had some special responsibility for promoting the development of district

* Presented at meeting of the Association of California Hospital Districts, Incorporated, October 20, 1959.

hospitals. This is not so, and I believe that by now we have convinced everyone that the department is interested in development of community hospitals to serve the public but makes no attempt to influence communities as to type of sponsorship. Hospital districts qualify for consideration in the Hospital Survey and Construction Program and the department works with many districts in administering this program. When this happens, it is simply a coincidence that the sponsoring organization is a hospital district. In fact, except on a few points, the department has no unusual direct contact with a hospital district. I have mentioned two specific points, however, where the department does have special responsibilities with reference to hospital districts. Both of these points concern the department's planning activities which are recorded annually in the state plan. The department's publication, *Hospitals for California,** summarizes this information.

The state plan is the department's attempt to provide leadership in coordinated planning of hospital expansion throughout California, so that this can be accomplished with the minimum investment of public and private funds needed to meet the requirements of the State's rapidly growing population. In the formation of new hospital districts, the department must certify for the hospital service area in which a proposed district is located, the estimated bed need, and the degree to which this is met by existing facilities. In districts which are operating hospitals, the board of directors annually must certify to the board of supervisors that rates for patient care are comparable to those charged in nonprofit hospitals located in the same hospital service area. These provisions relate to co-ordination of district hospitals in their expansion and in their operation with other hospitals in the vicinity.

Use of the California State Plan in the manner described above makes this an important document for district hospitals, in addition to the importance the plans has in establishing the basis under which grants are made in the Hospital Survey and Construction Program. This emphasizes that the state plan is not simply a device to provide a sequence in which public funds are distributed to assist in hospital construction.

In California, the co-operation of many organizations and the participation of many people in the preparation of the state plan have the objective of making the state plan an instrument for leadership in hospital planning. This leadership in hospital planning is intended to apply to general hospitals and to several other specialized types of facilities, such as psychiatric units, long-term care units, and rehabilitation centers. The planning concept incorporated in the state plan is that communities throughout California should take the major responsibility for solving their own hospital problems, and the effective way to do this is to define logical hospital communities which can consolidate their effort in support of hospital expansion programs. These hospital communities, as established in the state plan, are called "hospital service areas." At present, there are 110 of these in the state plan. Defining these areas is not simple. The general definitions under which they are established are contained in the department's publication, *Hospitals for California 1959.* In each hospital service area, an attempt is made to develop realistic estimates of hospital need and to compare these with facilities which exist. In making these estimates for general hospitals, occupancy rates, admissions per bed per year, and rate of population growth in the area are taken into consideration.

Planning for general hospitals and for all categories is particularly involved in California because of the State's rapid population growth. This is more evident in Los Angeles and in its suburbs than in other parts of the State. For this reason, the department has been doing a special study in Los Angeles for almost two years. This study appears to indicate that planning based on areas and beds per 1,000 population, is crude and needs refinement.

The Los Angeles metropolitan region in 1950 had a population of less than 5,000,000. It now has a population of almost 7,000,000 and is expected to have a population of approximately 12,000,000 in 1975. In the period 1950 to 1959, 90 new hospitals were built in Los Angeles, only seven of which had 150 beds or more and only 17 of which had 100 beds or more. If this experience is projected to 1975, an additional 160 new hospitals will be established, all but 30 of which will be smaller than 100 beds. Consideration of these facts has resulted in special planning principles being established in the state plan for the Los Angeles metropolitan region. These are outlined in *Hospitals for California 1959*, and special policies for Los Angeles are also contained in this publication.

In July and August 1959, the department, with the active co-operation of the Hospital Council of Southern California, the Hospital Council of San Diego, and the support of county medical societies in the counties of Los Angeles, Orange, Riverside, San Bernardino, and San Diego, conducted a survey in an attempt to learn more about the types of service provided in downtown and suburban hospitals of different sizes and character. Results of this survey are being tabulated and will be studied during the next several months. It is hoped that analysis of this information will assist in improving the knowledge on which hospital planning is based, so that a better pattern of co-ordinated expansion can occur in the future than has occurred in the past. This co-ordination will mean that planning will attempt to develop hospitals of a size and service capability to most adequately meet the public's needs. Application of this philosophy is needed to clarify relationship between hospitals and to reduce the possibilities of duplication and conflict between the hospitals. It appears probable that the concepts being developed in metropolitan Los Angeles will be applicable to other metropolitan communities and probably to all communities throughout the State.

California faces an enormous task in expanding its hospitals to provide needed community service. Of the 120,000 hospital beds we now have, approximately one-half have been built since World War II. This rapid rate of expansion must continue if hospitals are to expand at the same rate as the State's population. Currently, we have about 14,500,000 people in California. The department bases its estimates for planning purposes on the assumption that there will be 26,000,000 people in the State in 1975.

If hospital planning is to become more precise, it is possible that certifications required of the State De-

* This report has been distributed to all hospitals and local health departments in California. It is also available at depository libraries.

partment of Public Health in the formation of new hospital districts may need to take into account more than a simple comparison between the number of people and number of beds in a hospital service area. If fact, more precise planning may change materially the ideas under which hospital service areas are defined. Changes in the planning concepts which define hospital service areas will have an effect on the responsibility of hospital district boards in certifying that charges in the district hospital are comparable with those in nonprofit hospitals in the same service area.

It is very evident that medical science is requiring more and more from hospitals in support of patient care for which doctors are responsible. This hospital service is costly, technical, and apparently will become even more costly and technical. In my judgment, hospital districts have made a solid contribution to the development of the general hospital as a community medical center, and districts have a potential for continuing this solid contribution. An important factor in the success of hospital districts in meeting their community responsibilities has been the high level of competence which district directors have shown. In California, it is clear that the directors and the administrators they employ will be under pressure to continue performing in the future at the high level they have attained to date.

Health Research Facilities Grants Announced by USPHS

The U.S. Public Health Service has announced the award of 82 grants totaling $16,129,250 to help build and equip health research facilities in 72 institutions in 30 states and the District of Columbia.

The health research facilities construction program, now in its fourth year of operation, is administered by the National Institutes of Health, Bethesda, Maryland. Initially established in 1956 as a three-year program, it was extended an additional three years by the 85th Congress in 1958.

Like the initial program, the extended program is authorized at $30 million annually. It is designed to expand and improve the nation's facilities for medical research. Grants are made to both public and nonprofit hospitals, medical and dental schools, schools of public health, and other research institutions, and are awarded on a matching fund basis.

The grants made in California are: *Rancho Los Amigos Hospital*, Downey, new anatomical research laboratory, $293,756; *Childrens Hospital Society of Los Angeles*, additional award for research laboratory construction, $8,000; *College of Osteopathic Physicians and Surgeons*, Los Angeles, medical research building, $99,750; *Reiss-Davis Clinic for Child Guidance*, Los Angeles, new wing for psychiatric research and equipment, $28,213; *University of Southern California*, Los Angeles, biological research laboratory building, $1,000,000; *Stanford University*, Stanford, completion of basic science research building and equipment for the medical school, $238,964, and research laboratories for chemistry of natural products, $210,000.

Deputy Director Appointed By Dr. Merrill

Dr. Malcolm H. Merrill, State Director of Public Health, has announced the appointment of Harold M. Erickson, M.D., M.P.H., as deputy director of the department, effective January 4, 1960.

Dr. Erickson, Oregon's State Director of Public Health, has agreed to accept the position left vacant by the death of Dr. Frederic M. Kriete in July.

Harold M. Erickson, M.D.

Dr. Erickson brings to the department a wide experience at local, state, and national levels. He has been health officer of the State of Oregon since 1945, has served as president of the Association of State and Territorial Health Officers, and was one of the U.S. delegates to the Seventh World Health Assembly at Geneva, Switzerland.

Dr. Erickson received his medical degree at the University of Oregon in 1933 and his master's degree in public health at Johns Hopkins University in 1940.

His local health department experience was as health officer and assistant county physician of Multnomah County, Oregon, 1935-36 and as Wesco County Health Officer, 1937-40. He went to the Oregon State Board of Health in 1940 as Director of Maternal and Child Health, became Assistant State Health Officer in 1942 and State Health Officer in 1945, the position he is leaving to come to California.

Mosquito Control Seminar Held

Twenty-four administrators from local mosquito abatement districts throughout California and from one other western state recently attended a four-day conference at the Asilomar Conference Grounds in Pacific Grove. The seminar focused on the problems administrators face in running small- to medium-sized tax-supported agencies. The program was jointly sponsored by the California Mosquito Control Association, the California State Department of Public Health, and the University of California School of Public Health in co-operation with the School of Business Administration, Graduate School of Business Administration, and University Extension, Northern Area.

STATE DEPARTMENT OF PUBLIC HEALTH
BUREAU OF HEALTH EDUCATION
2151 BERKELEY WAY
BERKELEY 4, CALIFORNIA

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HOSPITAL CENTERED MEDICAL SERVICES? *

RUSSEL V. LEE, M.D.
Palo Alto Medical Clinic, Palo Alto, California

The present deep concern about the distribution of medical services is based upon a simple fact. They are now worth having. More than this they are essential if a nation or a people is to maintain its strength. It is clearly demonstrable now that the health of an individual, his freedom from preventable disease, his life expectancy and his chance of avoiding premature death depend definitely and directly upon his access to reliable health services. And what applies to the individual applies to the nation.

This being true has resulted in a new concept, almost a new principle for social organization. This is that no person should be denied access to health services which he needs. As stated in another way, it is the obligation of society to see that everyone gets all the necessary medical care which is available. This principle has by no means received universal acceptance. There are those who say that the individual should look after himself, that this is socialism. But when faced with specific cases—the child in need of emergency surgery, the injured and bleeding who needs a transfusion to live—no one objects to the services being provided regardless of who pays. When it is demonstrated that life and health depend upon these services, the demand naturally develops. The father of a family, the head of a labor union, the president of a great corporation are equally determined that these great benefits will not be denied to those dependent upon them. And no state can stand aside while its citizens sicken and die unnecessarily.

This great and insistent demand, the humanitarian impulses, and the political expediency as well, have resulted in many countries in socialized medicine. Hospital beds and pills, the services of physicians, surgeons, and nurses are the "bread and circuses" dispensed by these modern governments. They do it because they must. They are forced by considerations of survival—the nation must be strong to survive and must be healthy to be strong. They are forced by the demands of the people (once installed, no system of socialized medicine has been abandoned). They are forced because no other than a governmental agency exists capable of furnishing the services. Of all the great nations only the United States has been able to supply these services under a partly free enterprise system and supply them in sufficient quantity and of acceptable quality. In our state of health we are not perhaps the very best of the nations as measured by measureable standards but we are close to it. And we have not achieved it completely without governmental intervention, but it is less by far than in other nations. It is important to our way of life that we continue as far as possible to follow the free enterprise system, it is essential that we devise ways of getting the services in the first place and distributing them to those who need them in the second place. These services are of three sorts: hospital and nursing home facilities; medical and paramedical personnel services; and the provision of materials—drugs, prosthetics and the like.

In the case of hospital facilities, government is already deeply involved. If we include the beds for mentally ill, 70 percent of the hospital beds are presently provided by governmental agencies. No hospitals are built for private profit, almost all are built either entirely with governmental funds or with aid in the form of Hill-Burton grants. The others are built by philanthropy. So in the provision of hospital services already we have accepted a great deal of governmental participation. To go all the way and say that the government should provide hospital facilities for all, as it does school facilities, would not be a great step and it may well come and sooner than most people expect. But in our present mood and in the light of our past practices, private operation of hospitals seems desirable and is possible for a great many of the people.

The hospital has grown in importance year by year and is coming to be recognized by doctors and the public as the very center of medical and health activities. It is proper therefore in this consideration of the distribution of medical care to begin with the hospital, and in fact to center our attention to it as the most important agency in the distribution of medical services. The solution suggested here will be based upon the hospital and the hospital staff.

Before the hospital can furnish services, it must be built. An immediate, extensive and comprehensive program of hospital construction should be undertaken. Half of the present hospitals should be torn down and replaced. Largely or entirely by governmental help, we should immediately build at least five beds for each thousand of the population. This program should take precedence over the program of superhighways, largely devoted to filling more hospital beds. There is no question but that this great country is affluent enough to build a magnificent hospital system to supply every need to its people. If we do not, the communists will put us to shame. We can't distribute hospital services until we have them to distribute. Ideally these hospitals should have about 500 beds and should each serve about 100,000 people, with a staff of about 200 doctors, representing all specialties.

Now for the plan for utilization. Everyone, every person that is, who desires it should "belong" to his hospital as he "belongs" to his church or lodge. He should pay dues to his hospital association sufficient to provide him and his family with basic hospital needs, as much, as rich, as extended as he (expressed through his association) desires. The more services provided for, of course, the higher the dues should be. But basic ward beds and ancillary services sufficient to cover the actuarily predictable utilization should be provided for all. The county or other entity responsible for indigents could take out memberships for indigents at the same rates. If an unforeseen utilization resulted in a deficit, an assessment could be levied on the association to make up the deficit. If there were a surplus, a dividend could be returned to the members or additional services could be rendered. These hospitals would follow the pattern being set for the district hospitals, would be governed by a board locally elected and could reflect in

* Presented at the annual meeting of Western Branch, American Public Health Association, San Francisco, June 4, 1959.

their policies the desires of the particular community they serve which might vary widely in various parts of the country. The great disadvantages of the nationwide or statewide systems of hospital insurance with the waste, overutilization, and lack of response to the customer's desires could be avoided. Under this system, fee-for-service hospitalization for those who do not belong to the association could be provided side by side with that provided to members. And members who wanted and could pay for more than basic ward beds, private rooms, special nurses, etc., could of course do so and increase the hospital revenue.

The medical services could be contracted for in a similar way with the hospital staff, which, organized as a group practice clinic (for the provision of these services to the association members), could contract, for a fixed agreed upon fee, to furnish all needed medical and surgical services to the members. The individual doctors on the staff could have in addition private fee-for-service patients, if attendance upon these did not deprive the members of services contracted for. In this way the great advantages of group practice as an efficient device for distributing medical services of a high order could be utilized and the desires of physicians for independent status could also be preserved.

This system to be complete would require an additional indemnification type of insurance policy to cover the members when they were away from home. Such policies exist and are not expensive.

The provision of supplies could best be handled by the association acting as a co-operative purchasing agent for its members, who then could either pay individually for what the individual used or could furnish them free to the members and cover it with an additional assessment. (A matter of policy for the association itself to decide.)

This then would be a superb system of general hospitals built by governmental agencies, governed by locally elected boards furnishing hospital services on a prepaid basis for all who chose to join a co-operative hospital association, staffed by a completely rounded-out staff of specialists who, organized as a group practice partnership, would furnish prepaid medical care to the members of the association and in addition fee-for-service care to those who did not belong. Ultimately these associations could take in the indigents with their dues paid for by the appropriate agency. In time, perhaps, veterans could receive such memberships in lieu of the kind of care the Veterans Administration distributes. It would improve our mental health situation if there were attached to each of these general hospitals a mental disease unit with ultimately breaking up the great state hospitals. These things can come as the system develops.

This is a plan which would operate in the pattern of free enterprise, with the highest degree of local autonomy and local responsibility, which would free us from the abuses of the present cumbersome system of prepayment and insurance and bring medical care of high quality to all the people at a price they can afford to pay.

CCLHO Elects Officers At Fall Meeting

Everett M. Stone, M.D.

The California Conference of Local Health Officers elected officers for 1959-1960 at their 25th semiannual meeting at the University of California Conference Center at Lake Arrowhead, October 7-8. The incoming president is Dr. Everett Stone, Riverside County Health Officer. He succeeds Dr. Henrik L. Blum, Contra Costa County Health Officer. Dr. Herbert Bauer, who was secretary last year, is vice president. Dr. Dwight M. Bissell, San Jose City Health Officer, is the new secretary.

All local health officers in California are members of the conference, which was established by the Public Health Assistance Act of 1947.

At the October meeting, approval was given to the following matters:

1. A study of California lien laws, in conjunction with the California Medical Association, the California Hospital Association, California Supervisors' Association, League of California Cities, and other associations.

2. A possible mental health institute for health officers.

3. Participation in a program to develop practicable field sanitary facilities which will prevent contamination of food crops and will provide handwashing facilities for the agricultural worker in the field.

4. The inclusion of an increase of $68,000 in federal grant-in-aid funds for the Special Projects Grant budget this year.

5. An occupational health program guide.

6. A pilot study of surveillance techniques for measuring the prevalence of antibiotic-resistant infections in hospitals, to be carried out by local health departments, certain carefully selected hospitals, and the State Department of Public Health.

7. A method for evaluating new sanitation methods and equipment.

8. A proposed meeting with representatives of local medical societies in California, to be held in Los Angeles, February 23, 1960.

The conference also commended Governor Brown for his interest in traffic safety.

A subsidy for financing a tuberculosis home care program was opposed.

Following is a list of committee appointments for the conference for 1959-1960.

Executive Committee

Everett M. Stone, M.D., President
Herbert Bauer, M.D., Vice President
Dwight M. Bissell, M.D., Secretary
Austin W. Matthis. M.D., Chairman of CAP (Ex officio)

Committee on Administrative Practices

Austin W. Matthis, M.D., Chairman, Imperial
Herbert Bauer, M.D., Yolo
Dwight M. Bissell, M.D., San Jose City
Morris L. Grover, M.D., Pasadena
Edward Lee Russell, M.D., Orange
Ellis D. Sox, M.D., San Francisco
Everett M. Stone, M.D., Riverside
Donald R. Taves, M.D., Shasta
George M. Uhl, M.D., Los Angeles City
Robert S. Westphal, M.D., Stanislaus
Jack J. Williams, M.D., San Joaquin

Committee on Health Services

Morris L. Grover, M.D., Chairman, Pasadena
Carolyn B. Albrecht, M.D., Marin
J. B. Askew, M.D., San Diego
Henrik L. Blum, M.D., Contra Costa
DeWitte T. Boyd, M.D., Kern
Ira O. Church, M.D., Sacramento
Russell S. Ferguson, M.D., Santa Cruz
Myron W. Husband, M.D., Monterey
Joseph T. Nardo, M.D., Santa Barbara County
Albert E. Raitt, M.D., Colusa

Leon M. Swift, M.D., Sutter-Yuba
Richard White, M.D., Placer

Committee on Health Facilities

Robert S. Westphal, M.D., Chairman, Stanislaus
J. B. Askew, M.D., San Diego
Harold D. Chope, M.D., San Mateo
Russell S. Ferguson, M.D., Santa Cruz
Lester S. McLean, M.D., Humboldt-Del Norte
Edward Lee Russell, M.D., Orange
George M. Uhl, M.D., Los Angeles City

Committee on Environmental Sanitation

Jack J. Williams, M.D., Chairman, San Joaquin
D. L. Albasio, M.D., Calaveras
A. Frank Brewer, M.D., Merced
Merle E. Cosand, M.D., San Bernardino County
Clarence Davis, Jr., M.D., Amador
Frank E. Gallison, M.D., Ventura
Roy O. Gilbert, M.D., Los Angeles County
Victor H. Hough, M.D., Inyo
James C. Malcolm, M.D., Alameda
Angus A. McKinnon, M.D., El Dorado
William B. McKnight, M.D., Plumas
Lester S. McLean, M.D., Humboldt-Del Norte
Eugene W. Minard, M.D., San Bernardino City
Jack C. Nichols, D.O., Mono
John H. Pasek, D.O., Alpine
Clark M. Richardson, M.D., Tulare

Committee on Communicable Disease and Laboratories

Donald R. Taves, M.D., Chairman, Shasta
James L. Barnes, M.D., Sierra
Arnold W. Brockmole, M.D., Butte
Sterling S. Cook, M.D., Napa
Garold L. Faber, M.D., Fresno
Helen Hart, M.D., Santa Barbara City
Roswell L. Hull, M.D., San Benito
C. R. Kroeger, M.D., Mendocino
Alvin R. Leonard, M.D., Berkeley
I. D. Litwack, M.D., Long Beach
Henry G. Mello, M.D., Solano
V. Thery Ness, M.D., Trinity
Norman Nichols, M.D., Mariposa
Stanley Ogush, M.D., Nevada
Lloyd W. Shannon, M.D., Modoc
Hubert O. Swartout, M.D., San Luis Obispo
W. Elwyn Turner, M.D., Santa Clara

Committee on Legislative Information

Appointments to be made, if indicated.

Ad Hoc Committee on Milk Inspection

Appointments renewed, pending completion of assignments.

Ad Hoc Committee on Hygiene of Housing

Appointments renewed, pending completion of assignments.

"Most of the major advances in control of disease over the past 20 years—the antibiotics, vitamins, antimetabolites, antimalarials, insecticides, steroids, isotopes, antiviral vaccines, and psychopharmacologic agents—derive from chemical research."—*James H. Shannon, M.D.*, Director, National Institutes of Health, P.H.S., *Health News*, Vol. 36, No. 2.

Problems of the Aging in State Heard by Senate Subcommittee

Development of comprehensive, long-range health plans for the aged were recommended by representatives of the California State Department of Public Health in statements presented to the Subcommittee on Problems of the Aged and Aging of the U.S. Senate Committee on Labor and Public Welfare. The subcommittee, chaired by Senator McNamara of Michigan, met in San Francisco October 29. Dr. Lester Breslow, Chief, Bureau of Chronic Diseases, and Gordon Cumming, Chief, Bureau of Hospitals, were the department's spokesmen.

The subcommittee was told that the medical bill for California's 1.2 million citizens over 65 years of age amounts to about $288 million per year. For the average person over 65, the medical costs would come to $240 per year, which is about 20 percent of their personal income, contrasted with about 5 percent for the rest of the population. This estimate was given as a conservative one, and did not include such costs as those for dental services, home nursing services, and medical appliances. About half of California's medical bill for the aged is paid out of federal, state and local funds; the rest is paid by the patient, insurance benefits, private philanthropy, contributed services of physicians and other sources.

Mr. Cumming reported that "approximately 5 percent of the aged find it necessary to live more or less continuously in institutions, requiring substantially more medical and institutional care than is required by younger age groups. Older persons not only become ill more often and require hospitalization, but also require longer periods of hospitalization for each illness."

Doctor Breslow pointed out that "major issues still confronting us in the field of health care for the aged include splinteration of services and inadequate quality of services."

"Multiple efforts by federal, state and local public health, welfare, hospital, and other governmental agencies; private organizations; insurance companies, professional societies and other agencies remain unco-ordinated. The patchwork approach to such a major problem leaves many gaps. An important need is to plan carefully for the use of all present resources on a statewide basis and in each community; then to develop the necessary additional services."

Speaking on the present inadequate quality of services, Doctor Breslow said that "while here and there high quality services for the aged have been developed, the fact remains that present patterns of care leave much to be desired. Historically, we have approached the care of the tuberculous, the mentally ill, and now the chronically ill and aged by putting them away in institutions. We first provide only meager attention, to maintain existence. Subsequently, we learn that early intensive treatment is effective. Then we begin to develop better services, both in institutions and outside of them. . . .

"In the future, both governmental and private efforts to expand health services for the aged should give major attention to assuring desirable standards of quality of care. Otherwise, funds will not only be wasted but may actually tend to lower the quality of services."

Doctor Breslow made the following specific recommendations to the subcommittee:

1. Development of comprehensive, long-range state health plans for the aged, in accordance with federally established criteria to assure a minimum nationwide standard of quality. Congress should make funds promptly available to start this planning in the pattern of the Hill-Burton Hospital Survey and Construction Act.

2. Initiation of projects in the states to fill obvious gaps in health care of the aged and to develop new patterns of care, with emphasis on diagnostic services, rehabilitation, and home care. These projects should be consistent with the state plans. Congress should make prompt appropriation of funds to initiate such projects, in the established pattern of federal-state health programs.

3. As the states are developing comprehensive, long-range health plans for the aged, the Congress should determine the source of funds to be used for the large expansion of health services for the aged which is going to be needed.

Mr. Cumming summarized his statement in this way: "We believe the institution for long-term care should develop a greater competence to provide for the patient as his condition changes. This suggests that the hospital and nursing home in the future should provide a relatively wide range of services for the patients

which they accommodate. We are hopeful that hospitals in the future will recognize a definitely increased responsibility for providing long-term care in units which function as departments of general hospitals or in separate institutions which maintain close ties and affiliations with general hospitals.

We believe that standards of accreditation which are supported by voluntary effort and licensing standards developed by government must continue to press for higher levels of care. The present weakness in these standards, in our judgment, is that they fall short of recognizing that patient care can be much more positive than it is at present.

It is our view that the institution for long-term care in the future, like the general hospital of the future, needs to develop into a community health center through which programs of preventive medical services for the people can develop.

It is evident that development of long-term care facilities in this direction will cost money. We believe, however, that society will be best served by strenuous effort to reduce the 5 percent of our aged population which now must be accommodated in institutions for long-term care."

Reported Cases of Selected Notifiable Diseases, California, Month of October, 1959

Disease[1]	Cases reported this month			Total cases reported to date		
	1959	1958	1957	1959	1958	1957
Series A						
Amebiasis	39	52	253	526	915	1,781
Coccidioidomycosis	47	27	13	241	175	158
Measles	494	687	436	39,751	33,963	52,537
Meningococcal infections	9	15	23	168	163	148
Mumps	943	792	972	10,883	15,211	17,549
Pertussis	170	349	344	2,153	3,442	2,425
Rheumatic fever	9	8	11	122	117	120
Salmonellosis	102	125	253	976	888	1,396
Shigellosis	228	293	237	1,735	1,584	1,466
Streptococcal infections, respiratory	2,738	1,668	565	19,477	11,845	6,920
Trachoma	--	4	--	23	6	81
Series B						
Chancroid	10	9	7	67	77	52
Conjunctivitis, acute newborn	2	4	1	7	18	4
Gonococcal infections	1,340	1,856	1,734	14,138	14,606	13,762
Granuloma inguinale	1	--	2	2	8	7
Lymphogranuloma venereum	--	4	2	15	28	17
Syphilis, total	465[a]	584	666	5,671[b]	5,184	5,169
Primary and secondary	68	88	65	870	506	400
Series C						
Anthrax	--	--	1	--	--	1
Brucellosis	3	4	4	13	32	43
Diarrhea of the newborn	1	2	23	55	19	42
Diphtheria	1	1	--	6	6	8
Encephalitis	53	55	50	356	500	482
Food poisoning (exclude botulism)	77	99	277	1,345	941	1,107
Hepatitis, infectious	218	189	153	2,154	1,657	1,618
Hepatitis, serum	13	8	15	79	97	85
Leprosy	1	2	--	15	12	13
Leptospirosis	--	--	--	3	2	1
Malaria	1	6	7	24	21	34
Meningitis, viral or aseptic	79	206	na	747	800	na
Poliomyelitis, total	69	67	82	392	259	614
Paralytic	60	60	54	333	190	250
Nonparalytic	9	7	28	59	69	364
Psittacosis	--	1	2	14	16	26
Q fever	6	3	1	59	35	39
Rabies, animal	12	7	25	112	146	162
Rabies, human	--	--	--	1	--	1
Rocky mountain spotted fever	--	--	--	3	--	--
Tetanus	6	3	5	38	39	27
Trichinosis	2	1	--	7	5	7
Tularemia	--	1	--	4	4	2
Typhoid fever	9	19	24	67	61	71
Typhus fever (endemic)	--	--	3	3	3	9
Other[2]—						
Botulism	--	--	--	2	1	2
Relapsing fever	--	--	--	3	--	3
Plague	--	--	--	2	--	--
Series D						
Epilepsy	250	390	218	3,405	3,441	2,593
Tuberculosis[3]	--	--	--	4,388	4,988	5,409

[1] Diseases are grouped in Series A, B, C and D to simplify processing in the local health departments. The details of this classification are given in the "Handbook of Morbidity Reporting Procedures and Epidemiologic Followup for Local Health Departments—1958 Revision."

[2] These spaces will be used for any of the following rare diseases if reported: botulism, cholera, dengue, plague, relapsing fever, smallpox, typhus epidemic, yellow fever.

[a] Excludes 98 cases found positive by special serologic survey (Mexican National farm workers at Border Reception Center, El Centro).

[b] Excludes 4,179 cases found positive by special serologic survey (Mexican National farm workers at Border Reception Center, El Centro).

[3] Tuberculosis cases are corrected to exclude out-of-state residents and changes in diagnosis.

Hospital Advisory Council Appointments Announced

Governor Edmund G. Brown has announced the appointment of one new member, John Horace Snider of North Hollywood, to the State Advisory Hospital Council. He reappointed three other members.

All appointments were for two-year terms.

Those reappointed are Dr. C. V. Thompson of Lodi; Sister M. Laurencita, Administrator of St. Agnes Hospital, Fresno; and V. K. Meedom, Crescent City, former Del Norte County supervisor, banker, and chairman of the board of directors of the Del Norte County Hospital District.

Snider, 55, is president of District 727, International Association of Machinists, and a member of the board of directors of the San Fernando Valley Presbyterian Hospital. He replaces C. T. Lehmann, Vice President of the California State Federation of Labor, whose term on the hospital council expired October 1.

Active in civic and welfare movements, Snider has served on the board of governors of the Los Angeles Community Chest and has been a leader in Red Cross, United Fund and hospital fund drives. He first interested himself in hospitals on behalf of union members seeking better health insurance coverage.

Dr. Thompson, a physician in private practice, has been serving on the council since 1954. Meedom was first appointed in 1947, and Sister Laurencita in 1957.

It is hard to realize that the combined death rates of tuberculosis and pneumonia alone in the early 1880s closely approach the current death rate of policyholders of ordinary life insurance from all causes.—*Frederic W. Edser,* President, Metropolitan Life Insurance Co., quoted in *J. A. M. A.*, Vol. 167, No. 11.

Pioneer in Public Health Nursing Dies at 87

Funeral services were held for Miss Agnes Talcott, 87, pioneer in the public health nursing field, on November 6 in Los Angeles.

Miss Talcott, who began her California career as director of nurses for the Los Angeles City Health Department in 1916, devoted most of her life to building the profession of public health nursing.

In addition to her 26 years directing the nursing activities of the Los Angeles department, Miss Talcott was the first nurse in the United States to become a health commissioner when she was appointed to the Los Angeles City Board of Health Commissioners in 1944, two years after her retirement from the department. She served in this capacity for 7½ years.

Instrumental in changing public health nursing from the compartmentalized and specialized operation it was in 1916 to a general family nursing program of the type later accepted in health departments throughout the country, Miss Talcott was able to quickly reassign and deploy nurses to cope with potentially disastrous epidemics of bubonic plague and smallpox that broke out in the 1920's, as well as many large outbreaks of scarlet fever, diphtheria, and whooping cough.

An inexhaustible crusader to improve nursing education and to raise professional standards, Miss Talcott was loaned to the University of California at Berkeley to help establish its first public health nurse field training program. She also established nursing orientation within the health department for the training of undergraduates from local schools of nursing.

She was one of the founders of the California Organization for Public Health Nursing and its first state president; was twice elected to the board of the National Organization for Public Health Nursing; served as a director of the California State Nurses Association for nine years; and was active in the Los Angeles Council of Social Agencies.

Public Health Positions

Fresno County

Director, Public Health Nursing: Salary range, $6,036 to $7,548, to direct a staff of 32 nurses and supervisors, based in modern quarters in one of the nation's richest agricultural counties. Fresno County is about halfway between San Francisco and Los Angeles, adjacent to three national parks, and within a few hours' drive of the Pacific Ocean. Low humidity in the summer and snow free in the winter. Plentiful housing reasonably priced in this area.

M.P.H. is required, plus five years of public health nursing, part of which must have been in a supervisory capacity.

Write, wire, or phone to: Edward W. Firby, Director of Personnel, Room 101, Hall of Records, Fresno 21, California. Complete and mail your application before December 31, 1959.

Napa County

Sanitarian: Salary range, $376-$458. Generalized public health program, 50 miles from San Francisco. Liberal benefits, starting salary dependent on training and experience. Automobile required; car allowance. For application contact Sterling S. Cook, M.D., Director of Public Health, P.O. Box 749, Napa, California.

San Diego County

Psychiatric Social Worker II: Salary range, $244.80 to $270.40 biweekly (approximately $532 to $587 monthly). To supervise casework activities of the Alcoholic Rehabilitation Clinic, a voluntary outpatient clinic under the administrative direction of the Director of Public Health. Duties include functioning as a member of the clinical team in the diagnosis and treatment of patients, administering the office routine of the clinic, planning and supervising the work of two psychiatric caseworkers and clerical assistants. County and state residence waived. A master's degree from an accredited school of social work and three years of paid professional experience with an approved psychiatric clinic or alcoholic rehabilitation clinic are required. For further information inquire of the County Civil Service Dept., Room 403, Civic Center, San Diego.

Motor vehicle idling, a definite source of air contamination, is reduced about 70 percent by a system of one-way streets, the New York City Department of Traffic has discovered.

Statistics from the department show that when long streets are converted to one-way operation, vehicular stops are reduced about 72 percent.

When an automobile slows for a stop it produces twice the amount of air pollution as when it is in motion. Four times as much pollution is produced by a vehicle standing with its motor idling as when it is moving, it was discovered.—*N. Y. State Health Dept. Bulletin,* July 27, 1959.

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